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ABSTRACT

In 2001, the Department of Health and Human Services (HHS) created a rural task force to develop strategies to improve HHS services in rural communities. Fifteen HHS agencies have programs serving rural communities; child- and education-related programs provide child welfare services, Head Start, health promotion and prevention services, training for rural health care providers, and prevention and rehabilitation services for substance abuse and mental illness. More than 450 individuals and organizations submitted comments in response to a notice in the Federal Register. Three findings emerged: HHS lacks a common definition of "rural"; lack of coordination has resulted in inconsistent application, implementation, and evaluation requirements in the more than 225 HHS programs serving rural communities; and the HHS policy development process does not consistently consider rural concerns. Task force recommendations include creating a formal structure within HHS for coordinating rural policy initiatives among HHS agencies as well as with external partners; creating an interagency workgroup to follow up on proposed strategies; ensuring that HHS processes include a specific focus on serving rural America; and developing a common methodology for determining HHS investment in specific communities and populations. The task force set five goals to improve provision of health care and human services in rural areas: 1) improve rural communities' access to quality health and human services; 2) strengthen rural families; 3) strengthen rural communities and support economic development; 4) partner with state, local, and tribal governments to support rural communities; and 5) support rural policy and decision making, and ensure rural voice in the consultative process. (Contains 41 notes.) (TD)

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ONE DEPARTMENT SERVING RURAL AMERICA

HHS Rural Task Force Report to the Secretary

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Executive Summary

On July 25, 2001, Secretary of Health and Human Services Tommy G. Thompson charged all HHS agencies and staff offices to examine ways to improve and enhance health care and human services for rural Americans. As the former governor of a predominantly rural State, Secretary Thompson recognizes the unique characteristics and needs of rural America and the important role HHS plays in ensuring healthy rural communities.

There are 65 million Americans who live in rural areas. Health care and social service programs in rural communities provide needed support of communities' well-being and represent a significant segment of local economies. Health care can represent up to 20 percent of a community's employment and income. In some lower income communities, federal support may account for as much as 50 percent of income in the community through funding for social and health services. These same programs, however, experience difficulties related to inadequate funds, personnel and support networks.

These challenges may compromise the effectiveness of service to rural residents. The loss or reduction of these services may adversely affect entire communities which suffer greater poverty, poorer health and less solvent economies. Ensuring the health and welfare of rural Americans is an essential part of a national policy that promotes the self-sufficiency of all Americans.

HHS Rural Task Force

In response to the Secretary's charge, HHS created a Rural Task Force to bring together representatives from each of the HHS agencies and staff offices. While members represented their respective agencies, the work of the Task Force was a unified effort and represented diverse perspectives as well as the central goals of HHS. Task Force members examined current program investment, regulatory policy and barriers to providing services, and developed strategies to improve HHS services in rural communities.

Recognizing the value of input from people living in rural communities, the Task Force invited public comment through a notice in the Federal Register published in August 2001. The Task Force encouraged people at the local, State, and Tribal level to share their thoughts about how the Department can better serve rural communities. More than 450 individuals and organizations shared their insight and experience. Comments ranged from people simply offering thanks to Secretary Thompson for his focus on rural services to technical comments about the impact of particular HHS health care financing regulations on small rural providers. Highlights from these public comments are featured throughout this report.

The Rural Task Force found that while there are statutory, regulatory and resource-related barriers that impede HHS' work in rural communities, there are also innovative strategies, both immediate and long-term, that the Department can implement to better serve rural communities.

Three Important Findings

The Rural Task Force's efforts resulted in three important findings:

- HHS lacks a common definition of "rural" or set of definitions that are used by all agencies and staff offices and that accounts for the gradient between metropolitan and rural areas. As a result, it is difficult to target grants, evaluate services, develop policy and quantify HHS' investment in rural and frontier communities.

- More than 225 HHS programs currently serve rural communities. Despite the breadth of support, rural communities struggle to access resources because individual programs have unique application, implementation and evaluation requirements. This lack of coordination in HHS is amplified at the State and local levels.

- The HHS policy development process does not consistently consider rural concerns. As a result, HHS policy decisions may have negative consequences for rural areas or fail to capitalize on opportunities to improve rural health and social services.

Recommendations to Improve Rural Health and Social Services Coordination

The Rural Task Force identified several actions that could improve the way that HHS manages rural policy development and services delivery. These actions have the potential to better integrate HHS' rural efforts and create "One Department, Serving Rural America."

- Create a formal structure within HHS with responsibility for coordinating rural policy initiatives among HHS agencies and staff divisions, as well as with external partners.

- Based on the work of this Rural Task Force, create an interagency workgroup that follows up on the proposed strategies. This workgroup would meet quarterly with the Secretary, or the Deputy Secretary, and report on HHS' progress towards achieving the goals proposed by the Task Force. It would update this plan periodically.

- Ensure that the annual HHS budget development, legislative and Government Performance and Results Act (GPRA) processes include a specific focus or crosscutting discussion about serving rural America.

- Develop a common methodology for determining HHS' investment in specific communities and populations.

Five Task Force Goals

The Rural Task Force set five goals to improve key areas of the provision of health care and human services in rural areas and developed strategies and activities for each goal area. The goals are:

> **Goal 1: Improving rural communities' access to quality health and human services.**
> **Goal 2: Strengthening rural families.**
> **Goal 3: Strengthening rural communities and supporting economic development.**
> **Goal 4: Partnering with State, local and Tribal governments to support rural communities.**
> **Goal 5: Supporting rural policy and decision-making and ensuring a rural voice in the consultative process.**

These goals were intended to broadly capture most of the Department's rural programs and policy-making efforts. Each agency and staff office was asked to develop a plan addressing these five goals. Five goal workgroups used these as a basis for developing an HHS-wide plan and making recommendations to the Secretary.

HHS Rural Task Force Report

This report describes the current health and social services challenges facing rural America, outlines HHS components whose programs currently serve rural and frontier communities, discusses the barriers that Task Force members identified, shares the common themes from the 450 public comments and details a number of strategies for improving health care and human services in rural communities.

The Rural Task Force drew from the experiences of rural leaders, existing literature and from the lessons shared through the public comments to frame the discussion under the "Rural America in 2001: Challenges and Opportunities." The strategies presented in this report represent a broad range of actions that could be taken. The next step in this effort will be to review these strategies and establish priorities. HHS' action on these suggestions can make an important and discernible difference in the lives of rural Americans. This report is a first step towards achieving this goal.

Secretary Thompson's Challenge to the Task Force

For the 65 million people living in rural America[1], the US Department of Health and Human Services' (HHS) mission to protect health and to provide help to those who need assistance is especially relevant. Health care and social service programs in rural communities provide needed support of communities' well-being and represent a significant segment of the local economies. These programs, however, frequently lack adequate funds, personnel and support networks.

Public health financing programs such as Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP) and social welfare programs such as Temporary Assistance for Needy Families (TANF), child care and child welfare also play a key role in rural communities, yet many rural service providers perceive that they work under regulations designed specifically for urban and suburban providers. This challenge may compromise the effectiveness and availability of service to rural residents. Concurrently, the loss or reduction of these services adversely affects entire communities who suffer greater poverty, poorer health and weaker economies.

On July 25, 2001, recognizing the unique characteristics and needs of rural communities and the relevance of HHS' mission to these communities, the Secretary of Health and Human Services, Tommy G. Thompson, issued a charge to all HHS divisions to improve and enhance the provision of health care and social services to rural Americans.

"As former governors of States with large rural populations, President Bush and I know how important it is for people outside of urban centers to have access to quality health care and social services. We have carried that understanding to the White House and HHS."
– Secretary Tommy Thompson

The HHS Rural Task Force was created under the leadership of the Health Resources and Services Administration's Office of Rural Health Policy and the Department's Office of Intergovernmental Affairs. The Rural Task Force brought together representatives from each of the HHS agencies and staff offices. Task Force members contributed specialized expertise about how their programs serve rural areas. With these unique perspectives, members examined program investment and regulatory policy in rural America as well as barriers to providing services. In addition, the Task Force asked for public input through a notice in the Federal Register. This report to the Secretary is the result of a multi-faceted analysis of all HHS programs and public comments. Highlights from these public comments are featured throughout this report.

The Task Force focused on improving five key areas: access to services; the strength of rural families; rural economic development; relationships with State, local and Tribal governments; and policy and research to inform decision-makers concerning rural communities.

Rural America in 2001: Challenges and Opportunities

Rural America today is significantly different from rural America in the mid-twentieth century or even rural America of the 1980's. It is also very different from the stereotypes that still characterize America's perceptions of its rural areas. These differences create formidable challenges for federal government agencies, programs and policy makers. Consideration of these differences, as well as important distinctions between rural and urban/suburban areas, is essential for understanding and improving health and social service programs in rural America.

Demographics

Significant and uneven rural population shifts have occurred throughout the last decade. The 1990 Census indicated that 61 million people lived in rural America. Projections for the year 2000 estimate that an increase of 3.9 million people occurred over the last 10 years in rural areas. Data collected by the USDA Economic Research Service show that 70 percent of rural counties grew in population from 1990 to 1999; in this same time period, 2.2 million more Americans moved from the city to the country than from the country to the city.

However, much of the rural population growth was largely concentrated in only 40 percent of rural counties. In addition, the number of rural counties with decreasing population rose from 600 in 1990-1995 to 855 in 1995-1999. Mining and farming dependent counties had the greatest relative fall off in population growth rates. Significant rural population declines continue in the Great Plains, the Appalachian coalfields and other areas where job losses in mining and farming persist.[2]

Population shifts throughout the last decade have included changes in many communities' racial and ethnic makeup. Many growing rural counties are experiencing concurrent growth in the diversity of residents. One source of increasing diversity is the change in immigration patterns in response to employment opportunities in rural areas. Many immigrants, especially Hispanic and Asian immigrants, are increasingly settling in the rural US. As with other characteristics, each region within the US has distinct patterns of racial and ethnic makeup. In general, non-metropolitan immigrants are concentrated in the Western and Southern US.[3]

"As a member of the Rural Caucus of the Texas Legislature, you can be assured that I am well aware of the problems and challenges of the rural areas of this great state. I applaud your efforts to identify and eliminate the regulatory barriers that hinder the efficient delivery of programs to rural areas." - Member of the Texas Legislature

In the South, non-Hispanic Black Americans accounted for more than 18 percent of the population in the most rural counties in 1998. In the West, American Indians and Alaska Natives constituted nine percent of the population and people of Hispanic origin constituted 11 percent in the most rural counties.[4] [5] "Rural minorities often live in distinct communities where poverty is high, opportunity is low, and the economic

benefits derived from more education and training are limited."[6]

The age distribution of rural communities' residents is also important for understanding the demography of these communities. In general, rural areas have a higher proportion of elderly residents. This trend is most dramatic in the South and Midwest[4]. From the perspective of HHS, this is significant in that the elderly use more health services than the non-elderly and use a significant proportion of social services. This contributes to a trend in which rural health care systems are increasingly dependent on Medicare as a primary funding source. Exacerbating the age differences between rural and metropolitan areas is that many of the youngest and most highly educated people are moving away from rural areas.[7]

Economics

The economies of rural communities have profoundly changed in the last fifty years. Most importantly, rural areas' economies are not one-dimensional, characterized only by agricultural activity. Rather, agriculture is a small segment of rural economies, accounting for only 7.6 percent of rural employment.[7] Rural communities also experience challenges in remaining economically competitive. These challenges include the inability to attract new investments, significant numbers of working poor and difficulty in achieving economies of scale in delivering health care, social services, education and training.[8] In addition, the "rural digital divide" continues to compromise educational, social service and economic opportunities. While some States have created Statewide infrastructures that enhance access to technology, many rural areas lack access to many of the communication and information technologies that urban and suburban areas have. For example, Internet access is not readily available in many rural areas. This inaccessibility has negative implications for an information technology-based "new economy" in rural areas.

Rural workers are nearly twice as likely as urban and suburban workers to earn the minimum wage. Rural workers also remain more likely to be under-employed and are less likely to improve their employment circumstances over time. Rural poor families are more likely to be employed and still poor.[7]

Between 1990 and 1996 there was a negligible change in non-metropolitan job earnings, remaining more or less around $22,493 (1996) per year per job.[10] The largest percent growth in non-metropolitan earnings between 1990 and 1996 occurred in the finance, insurance and real estate segments of the economy. The largest percent decline in earnings during this same time period occurred in agricultural services, forestry and fishing.[10]

Rural Areas Differ By Region

When considering rural America, it is important to remember that as each rural community is distinct, each US region has distinct characteristics that help define its rurality. For example, small towns and cities mark the Northeast US, particularly the New England area. This area's economy is largely dependent on fisheries and timber and has a predominantly white population. Thus, job decline in the fishery and timber industries has profoundly affected the economies of many of these communities.

The rural South is marked by high rates of poverty and racial diversity (with a high proportion of African Americans) and a rural economy dominated by low-tech manufacturing. The Midwest and Great Plains States have a higher percentage of rural elderly with shrinking communities. This region also relies heavily on agriculture and recent economic circumstances have included an increase of meat-packing and rendering operations accompanied by an influx of mostly Hispanic employees. The Southwestern border States see a high influx of immigrant workers. The West has vast frontier areas in which much of the land is federal park and Forest Service land. Consequently, the tax base is extremely limited.

Health and Social Services in Rural Communities

Effective, coordinated health care and social services in rural communities are essential for the health of these communities and well-being of their residents. The necessity of these services lies not only in their more obvious and immediate benefits, but also in their central role in local economies. Health care provides and generates up to 15 to 20 percent of jobs in many rural communities.[11] Social services also creates jobs and contributes to the health of local economies. In addition, twenty percent of total personal income in rural America comes from Federal transfers to rural residents, including Social Security and Temporary Assistance for Needy Families payments.[7] In addition, the presence of effective social services increases the likelihood that businesses will locate to these communities and further bolster the economy. Despite their importance, rural health care and social services struggle to remain viable because of inadequate service coordination and funding, workforce challenges, barriers and characteristics inherent to rural areas and residents they serve (e.g., relatively smaller and more dispersed populations).

Coordination of Services

The strong relationship between adequate income, sufficient food, strong social networks and good health necessitates coordination among various health care and social service agencies. This coordination is especially important in rural communities, where services and providers are limited in numbers. In many rural communities, service providers often make alliances with one another and exhibit extraordinary resourcefulness and resilience.[12] In some cases, rural providers facilitate a better response to people in need than urban providers because of smaller office size and more familiarity with clients. When given the opportunity, local administrators are often energized by the increased responsibility to attempt innovations in social service provision.[13]

Our seniors are literally dying on the farm, slowly starving trying to live on toast and coffee, because they are so lonely, and they don't know how to reach out." - Rural Resident

However, coordination in rural communities is difficult for a number of reasons. Some services are becoming more fragmented as rural service providers specialize in an attempt to simplify administrative responsibilities and to meet federal grant requirements.[14]

In addition, State and federal authorities, often make decisions regarding funding for specific programs based on cost. Cost-based decisions invariably disadvantage rural areas because it costs more to serve a dispersed population than a concentrated one.[14] Possibly the most important factor in fragmentation and lack of coordination in rural areas is the continuing conceptual and practical separation among primary health care, behavioral health care and social services. Although health and social welfare are strongly associated with one another, in many cases federal, State and local planning efforts continue to address them separately.

Rural American Culture

The culture of rural America also plays an important role, both positive and negative, in the delivery of health and social services. Because rural communities have relatively small populations, strong social networks often exist accompanied by a sense of familiarity, or of knowing people in the community. Such phenomena provide supportive safety nets and empathy with those in need of services. Conversely, this familiarity may create a sense of limited privacy and stigma associated with certain services, like mental health and substance abuse treatment. The strong ethos of reliance on informal rather than formal institutions, independence and individualism in many rural communities may also hinder the effectiveness of these services as they limit rural residents' willingness to use them. Rural residents may also perceive that certain social welfare issues (i.e., substance abuse among TANF recipients) are urban issues and will not support services that address such issues in their communities.[14]

Access

Two central issues predominate when considering health and social services in rural communities: lack of access and, related to this lack of access, poorer health and greater poverty. A number of factors inherent to rural areas affect rural residents' access to health care and social services. Geography plays an important role in limiting rural residents' access because they often must travel longer distances to see health care and social services providers.[15] Service providers are frequently located in county seats or other population centers and often do not provide sufficient outreach to less populated areas. This reality often makes services much less accessible for all residents, but particularly those with special needs such as people with developmental disabilities who may need personnel assistance, home health services and respite care for their care givers. Complicating the longer travel distances is the scarcity of public transportation in rural areas. With limited public transportation, rural residents without reliable private transportation have fewer options for accessing these services. This dearth of transportation options also makes finding and maintaining employment difficult.[12 15] In addition, most government programs designed to address these issues have a specific population focus, like children with special health care needs or elderly. Many rural communities do not have a critical mass of these populations to qualify for specialized funding or to make the effort to apply worthwhile.

Rural residents in need of health care and social services may not have access to these services because there are no services in their communities, there is limited access to appropriate

transportation or telephone services or because they cannot pay for them. Research has illustrated that rural residents have less access to job training and education, health care, childcare, social services for the elderly and emergency services.[16] One study of 12 rural counties in four different States showed that public transportation, workforce development services, shelters, rehabilitative services and 24 hour childcare (an important service in some rural counties, where shift work is common) were available in few counties.[12] Such a lack of services limits rural residents' economic options. Service availability in rural communities varies by State. Thus, State policies and State spending priorities influence the location and availability of services.

An inability to pay for health care also compromises access to these services. Rural residents are less likely to have health insurance, a significant factor in their ability to access health services. In 1997, between 18 and 20 percent of central metropolitan and non-metropolitan county residents lacked health insurance, compared to 12 percent of suburban residents.[5 17] One cause of lower rates of insurance in rural areas is the prevalence of industries less likely to insure. There are also more part-time workers in rural areas than in urban areas. Rural residents are also less likely to have other benefits, like paid sick leave, than their urban counterparts.[18] One factor in this disparity is the prevalence of small businesses in rural areas. Many small businesses do not have the resources to provide health insurance.

Another important influence on the quality of rural health care and social services is the presence of qualified professionals. As of 2001, only 9 percent of the nation's physicians practiced in rural areas while roughly 20 percent of the nation's population lived in rural areas.[19] Currently, 22 million rural residents live in federally-designated Health Professions Shortage Areas (HPSAs), or Medically Underserved Areas (MUAs).[7] Mid-level health care providers, including physician assistants, nurse practitioners, counselors and certified nurse midwives, provide outstanding care in many rural communities. Nevertheless, varying State regulations regarding these practitioners' independence limits their use in many rural areas. Moreover, the supply of dentists in relation to population is as low as 29 per 100,000 in the most rural counties compared to 61 per 100,000 in metropolitan counties.[5 20] Recruitment and retention of social welfare professionals to rural areas are also often difficult. Most social work education programs focus on urban issues and pay relatively little attention to rural populations. Thus, many agencies' staff are provided little or no professional training specific to rural issues.[21] Rural agencies frequently offer lower salaries and require less education than their urban counterparts.

Statutory and Regulatory Barriers Related to Rural Health and Social Services

In addition to difficulties related to access, federal regulations have limited the effectiveness of rural health and social services.[19] One example of such a regulatory impediment is federal health care financing policy. Health care financing in rural areas exacerbates difficulties associated with accessing health care and provider shortages.[19] Medicare remains the primary source of health care reimbursement in rural areas

with Medicare patient expenses in 1998 accounting for 47 percent of total patient care expenses for rural hospitals, compared to 36 percent for urban hospitals.[22] The transition to prospective payment and fee schedules beginning with legislation in 1983 and most recently in 1997 and 1999 has threatened rural hospitals.[19] Because rural hospitals have lower volumes of patients with higher fixed costs, they often require special payment arrangements under prospective payment systems. Furthermore, poor financial status limits a hospital's ability to recruit and retain qualified health care providers, access needed capital and maintain other services like home health and skilled long-term care.[19]

Another example of federal legislation without explicit considerations of rural communities is the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), the act that reformed welfare. Inherent in this legislation authorizing the TANF program were four central assumptions. The first was that welfare recipients in all communities would move from welfare to work.[7] The federal government provided States significant flexibility in developing programs that would meet communities' diverse needs. Welfare to work policies mixed with a strong economy helped move a significant number of welfare recipients off of welfare. However, during a recession, States need to be aware that their rural areas may be at an increased risk of unemployment and may require additional supports.

A second assumption of welfare reform was that as workers transition off welfare, they can better support their families.[7] While many families have increased their capacity to support themselves, many jobs obtained by rural welfare recipients pay the minimum wage.[12] The average weekly salary of a non-metro woman with less than a high school education is 213 dollars.[7] In addition, family median income is typically lower in rural areas, with no rural districts in the top 100 family median income districts.[7]

"Typically, funding formulas for federal funds favor highly populated states, creating a variety of challenges for rural areas."
- Aging Program Director

Third, with the implementation of welfare reform, many state welfare programs provided welfare-to-work participants with supplementary services to enter the workforce, e.g., child care, transportation and substance abuse and mental health services. Because of the geography of rural communities, these services are difficult to provide and access. This lack of adequate services may impede successful employment.

Lastly, while States have flexibility in establishing work requirements under TANF, a limited range of activities count as work in determining State participation rates. The TANF rules and the High Performance Bonus measures encourage States to support families as they move into jobs and to help recipients retain and advance in jobs. Because rural residents often do not have access to formal employment, States may need to focus more proactively to help these residents find and obtain jobs that can more easily meet the participation rate standards.

TANF also provides a good example of a program administered through State block grants. Block grants provide States

the opportunity to design programs that address the unique needs of their communities including flexibility to prescribe the amount or scope of services to rural communities. Programs administering HHS block grants may want to consider providing technical assistance on the specific needs of rural health and social service providers.

Health and Social Service Outcomes in Rural America

Rural residents experience relatively poorer health and social welfare outcomes. The most dramatic health-related disparities between rural and urban residents are in the areas of mental health, substance abuse, public health outcomes and oral health.[5] Human services-related disparities include greater poverty and higher rates of unemployment.[7]

Some of the greatest rural/urban health disparities are in tobacco and illicit drug use. In 1999, adolescents living in the most rural counties had the highest percentage of cigarette use (19 percent compared to 11 percent of urban adolescents).[5 24] In addition, adults living in the most rural counties are the most likely to smoke (27 percent of women and 31 percent of men in 1997–1998).[5 25] Higher rates of smoking in the most rural counties may reflect two factors—delayed access to the medical and media resources that help change unhealthy behaviors,[5 26] and lower educational attainment, which is strongly associated with smoking.[5 27] Use of illicit drugs is also more prevalent in rural areas. In 1999, rural eighth graders were more likely to have used marijuana, cocaine, crack, methamphetamines and alcohol than urban eighth graders. In the case of methamphetamines, rural eighth graders were twice as likely to have used them than urban eighth graders.[28]

Some of these disparities may be related to inadequate access to mental health care, substance abuse treatment and youth development programs in rural communities. Difficulties include a shortage of mental health professionals and less funding for the community mental health system[14] that provides a substantial proportion of rural mental health services. The stigma of mental health care and substance abuse as well as concerns regarding confidentiality also limit rural residents' use of these services. With limited budgets, mental health care providers in rural areas are forced to focus on acute mental illness to the detriment of prevention programs.[14]

Also of concern are continued low rates of early prenatal care among rural women, especially those from certain minority groups and high rates of childbearing among rural teenagers.[29 30 31] Postneonatal death rates are also higher in rural areas.[32]

Better health insurance coverage and improvement of the public health service system could reduce some of these issues. However, rural public health programs and agencies also struggle because of budget restrictions and shortages of professionals. Non-metropolitan local public health agencies rely to a much greater extent on reimbursement for services (22 percent of their income is reimbursement, compared to 8.5 percent for urban public health agencies).[33] When confronted with budget shortages, local public health agencies often sacrifice services like family planning, mental health services and chronic disease monitoring, which have

less obvious impact on the community's overall health.[33] Non-metropolitan public health agencies also rely more heavily than metropolitan public health agencies on health care providers because of small staffs and budget restrictions.[34] This reliance can create difficulties as a result of the perpetual provider shortage in rural America.

Rural public and mental health services have the potential to address higher rates of unintentional death, injury and suicide in rural areas. Nationally, the age-adjusted unintentional injury and death rate increases significantly as counties become less urban.[35] The excess risk of unintentional injury and death in rural areas is associated with the higher incidence of fatal motor vehicle crashes and to some extent with more hazardous occupations such as commercial fishing, timber cutting and farming.[5 36 37] The higher incidence of fatal crashes is related to poorer road conditions in rural areas and also to lower rates of seat belt and child safety seat use, a situation that could be remedied with public health programs. Also important in increasing the rural fatal crash rate are long emergency medical services response times and lack of medical emergency and trauma care facilities.[5] Suicide rates for men also increase as urbanization declines. Possible factors in this increase include more increased firearm ownership in rural areas and fewer treatment options for mental illness. [5 38 39]

Elderly rural residents also experience poorer health than their urban counterparts. For example, the age-adjusted edentulism (total tooth loss) prevalence among seniors generally increases as urbanization declines.[5 25] This urban-rural increase in total tooth loss is consistent with the urban-rural decrease in the number of dentists per population.[5] Rural seniors also purchase more prescription medications than urban seniors. Although rural seniors have greater need for prescription medications, they are more likely than urban seniors to lack insurance coverage for prescription drugs. In 1995, 46 percent of rural elders lacked prescription coverage, compared to only 31 percent in urban areas.[7]

Specific social welfare outcomes are also related to inadequate access and regulatory barriers. To the extent that child care funding is based on population size and density, rural areas lose out. In addition, smaller dispersed populations in rural areas and associated transportation problems limit the feasibility of child care centers. Nationwide, 30 percent of all children under age five are cared for in a center setting. In rural areas, only 25 percent receive such care. The remaining children are in family-run child care homes, in-home care or relative care. While these settings may provide familial and community connections, they are less likely to be regulated.[40] Depending on State policies, some of these settings may not be eligible to receive subsidies through child care assistance programs such as the Child Care and Development Fund.

"We also have a lot of children who could use a head start program, within our community instead of shipping the little guys thirty miles one way to have class." - Rural Resident

Rural low-income families are more likely than their urban counterparts to work non-traditional hours. In addition, rural parents

often have to travel further to jobs, which means longer hours for their children in care and increased child care costs. Few child care options are available for parents who work evening or night shifts, or for the care of a sick child. While Head Start is among the few programs that allows for program funds to be used for the purchase, renovation or construction of facilities under certain circumstances, there is no targeted pool of funds for this purpose. Limited housing and affordable facilities may lead rural grantees to struggle to find adequate child care sites.

Poverty rates in rural areas are also higher than those in urban areas. More than half of rural seniors have family incomes below 200 percent of poverty, compared to roughly 40 percent of urban seniors.[7] Over half of rural children in female-headed households are in poverty (3.2 million children, 1996). In addition, 600 rural counties have the designation "persistent poverty county," signifying that more than 20 percent of the residents experienced poverty between 1960-1990. These counties are concentrated in the South, core Appalachia, the lower Rio Grande Valley and on American Indian reservations. While the largest numbers of rural poor are white, all minorities have much higher rates of poverty in rural areas.[7] The largest proportion of the rural poor live in the South, where welfare benefits are the lowest and where some of the more stringent welfare policies exist.[41]

Conclusion

As these data underscore, access to health care and social services remain critical rural issues. Also apparent is the interdependence of health care, social services and economic development in rural communities.

HHS' unique and important role in rural communities provides us with an opportunity to redefine, with rural Americans, the meaning of a healthy rural community and how HHS can organize and innovate its services to correspond with this new definition. This redefinition will recognize that, to be healthy, a community needs not only health care, but a thriving economy, low levels of poverty and reliable social service networks.

The Task Force used this perspective of integrated, holistic services in its analysis of and strategic plan concerning rural health and social services. This new, invigorated understanding will enhance and unify HHS' efforts in pursuing with energy and commitment the realization of truly healthy communities throughout America.

One Department Serving Rural Communities

The HHS Rural Task Force conducted a department-wide assessment of how HHS programs currently serve rural and frontier communities. During the course of this examination, the following key findings emerged.

- ***It is difficult to assess the Department's investment in rural America.***

HHS administers hundreds of programs that potentially support health and human services in rural communities both directly and indirectly. These programs are administered in myriad ways. In addition, the areas and communities in which some programs serve are more clearly defined as rural or urban than other programs' service areas. For example, HHS administers grants directly to community-based providers, groups or organizations. Medicare also makes payments directly to health care providers. These investments can be easily determined as either rural or urban.

Other program spending by the Department is not as easily identified as rural or urban. For example, there are no mechanisms available to consistently determine the proportion of rural funding in State-administered programs such as Medicaid, SCHIP, TANF, the Social Services Block Grant and the Maternal and Child Health block grant.

Many HHS programs provide funds directly to State health departments or local agencies that then redistribute those funds in a variety of ways, some of which are categorical in nature. There are other instances in which a central grantee such as a community health center may receive an award and serve as the grantee of record. However, many of these grantees also operate networks of satellite clinics in both urban and rural locations. There is currently no means for determining the proportion of this spending that benefits rural areas.

HHS also funds a significant amount of health and human services research. While some of these studies may focus on or at least discuss some rural issues, most are not solely focused on rural issues. This funding is typically awarded to universities, policy institutes or individuals located in urban areas. Only HRSA's Office of Rural Health Policy and NIH offer rural-specific services research.

- ***Programs define how they serve rural in different ways.***

The standard definition of rural used by the Office of Management and Budget designates communities based on whether they are located in metropolitan (i.e., urban) or non-metropolitan (i.e., rural) counties. While this definition is used by the Medicare program and several of the HRSA programs, it is not used by any of the other HHS agencies and offices.

Some agencies, such as the Administration on Aging (AoA), use their own methodology based on specific program needs. Other programs allow their grantees to designate themselves as rural if they claim to serve rural residents. There are other HHS programs such as many of those run by the Centers for Disease Control and Prevention that categorically

focus on specific diseases or health issues and fund both rural and urban programs with no distinction between the two. Given this variability, there is no easy way to determine the Department's rural investment.

- ***More that 225 HHS programs currently serve rural communities.***

Task Force members looked across their agencies and staff offices and determined that rural communities are currently served by more than 225 HHS-funded programs. These programs range from grants targeted specifically to rural communities to State-based programs like TANF and Medicaid.

All of the Agencies and staff divisions provide service to rural individuals and communities. A summary of the key programs and their impact on rural communities follows.

"It would be interesting to trace dollars from the national level to the local level where services are actually delivered. What percentage of those dollars actually make it to 'where the rubber meets the road'?"
- Program Director in Idaho

Agency Programs that Serve Rural Communities

Administration on Aging (AoA) - AoA supports a nationwide aging network, providing services to the elderly, especially to enable them to remain independent. AoA supports 291 million meals for the elderly each year, including home-delivered "meals on wheels," provides transportation and at-home services, supports ombudsman services for the elderly and provides policy leadership on aging issues.

AoA's services in rural areas are administered principally through the Older Americans Act Title II-C (Nutrition Services), Title III-E of that act, the national Family Caregiver Support Program and through Title VI, Part C - the Native American Caregiver Support Program.

Administration for Children and Families (ACF) - ACF is responsible for numerous federal programs that promote the economic and social well being of children, families, individuals and communities. Actual services are provided by State, county, city and Tribal governments, and public and private local agencies. Among its major programs are the Temporary Assistance for Needy Families, the nation's child support enforcement system, foster care and adoption assistance, child care and child welfare services, child abuse and neglect programs, assistance for people with disabilities and the Head Start program.

It also administers a number of community and economic development programs including several specifically for Native Americans. The community services grant program provides essential funding to a network of more than 1200 community-

based multi-service agencies called community action agencies.

Agency for Healthcare Research and Quality (AHRQ) - AHRQ supports research designed to improve the quality of health care, reduce its costs, improve patient safety, address medical errors and broaden access to essential services. The research sponsored, conducted and disseminated by AHRQ provides evidence-based information that helps health care decision makers - patients and clinicians, health system leaders and policy makers - make more informed decisions and improve the quality of health care services.

Last year, AHRQ supported a number of studies that examined issues related to rural health, e.g., patterns of individual health plan coverage among rural populations, quality care and error reduction in rural hospitals and the rural response to Medicare+ Choice.

Agency for Toxic Substances and Disease Registry (ATSDR) - ATSDR works with States and other federal agencies to prevent exposure to hazardous substances from waste sites. ATSDR conducts public health assessments, health studies, surveillance activities, and health education training in communities around waste sites on the U.S. Environmental Protection Agency's National Priorities List.

Centers for Disease Control and Prevention (CDC) - CDC promotes health and quality of life by preventing and controlling disease, injury and disability. CDC seeks to accomplish its mission by working with partners throughout the nation and world to monitor health, detect and investigate health problems, conduct research to enhance prevention, develop and advocate sound public health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthful environments and provide leadership and training.

Centers for Medicare & Medicaid Services (CMS) - CMS administers the Medicare and Medicaid programs, which provide health care to America's aged and indigent populations. These programs serve about one in every four Americans, including more than 18 million children. Medicaid also provides nursing home coverage for low-income elderly. CMS also administers the State Children's Health Insurance Program (SCHIP) that covered an estimated 4.6 million children in FY 2001.

Food and Drug Administration (FDA) - FDA assures the safety of foods and cosmetics, and the safety and efficacy of pharmaceuticals, biological products and medical devices. For FY 2001, FDA programs do not have significant investments in rural communities. However, in FY 2001, FDA supported Innovative Food Safety Projects and a number of research grants that will benefit rural people.

Health Resources and Services Administration (HRSA) - HRSA's programs provide the foundation for the safety net of health care services relied on by millions of Americans. In 2001, HRSA provided preventive and primary health care to an estimated 10.5 million Americans through its nationwide network of 773 health center grantees, which includes community and migrant health centers and primary care programs for the homeless and residents of public housing,

many of which are jointly funded. The agency administers programs like the Ryan White Care Act, which give low-income people with HIV/AIDS the medication and care they need to get better or stay well, works with States to ensure that babies are born healthy and that pregnant women and children have access to health care and oversees the Nation's organ transplantation system.

HRSA helps train physicians, nurses and other health care providers, places them in communities where their services are desperately needed and also works to build the health care workforce through the National Health Service Corps. The Office of Rural Health Policy has responsibility for coordinating rural efforts across HHS, examining HHS policies on rural matters and currently administers eight grant programs that address rural health needs.

Indian Health Service (IHS) - IHS supports a network of 49 hospitals, 214 health centers, 287 health stations, school health centers, satellite clinics and Alaska village clinics and 34 urban Indian health centers to provide services to 1.5 million American Indians and Alaska Natives of 558 federally recognized Tribes.

National Institutes of Health (NIH) - NIH, with 27 Institutes and Centers, is the world's premier medical research organization and supports some 35,000 research projects nationwide in diseases like cancer, Alzheimer's, diabetes, arthritis, health ailments and AIDS. NIH invests in research and care for rural communities, principally through the National Cancer Institute, the National Institute on Drug Abuse and the National Institute of Mental Health. Other NIH Institutes fund smaller amounts of research directed toward rural communities.

Office of Intergovernmental Affairs (IGA) - IGA facilitates communication regarding HHS initiatives as they relate to State, local and Tribal governments. IGA is the Departmental liaison to State governments and serves the dual role of representing the State and Tribal perspective in the federal policymaking process as well as clarifying the federal perspective to State and Tribal representatives. In partnership with the US Department of Agriculture, IGA provides support to the National Rural Development Partnership each year. IGA also provides technical assistance and training on transportation coordination, much of which serves rural areas.

Office of Public Health and Science (OPHS) - OPHS serves as the focal point for leadership and coordination across the Department of Health and Human Services (HHS) in public health and science. OPHS provides direction to its program offices, including the Offices of Women's Health, Minority Health, Population Affairs, and Disease Prevention/Health Promotion. Additionally, OPHS provides advice and counsel on public health and science issues to the Secretary.

OPHS invests in the improvement of health care and research, principally through State and research institution-based programs including Centers of Excellence and Community Centers of Excellence in Women's Health, the Office of Population Affairs' Adolescent Family Life and Family Planning Programs and the Office of Disease Prevention/Health Promotion's Healthy People 2010.

U.S. Public Health Service Commissioned Corps (USPHS) - The U.S. Public Health Service Commissioned Corps, a cadre of 5,628 health professionals, engineers, and scientists, is one of the seven uniformed services of the United States. The mission of the Commissioned Corps is to provide highly-trained and mobile professionals who carry out programs to promote the health of the nation, understand and prevent disease and injury, assure safe and effective drugs and medical devices, deliver health services to federal beneficiaries and furnish broad health expertise in time of war or other national or international emergencies.

The Office of Public Health and Science provides policy and leadership for the Commissioned Corps through the Office of the Surgeon General. The Program Support Center, through the Division of Commissioned Personnel (DCP), provides day-to-day administration of the Commissioned Corps. DCP is the centralized human resource authority for all Commissioned Officers. Through participation in the Rural Task Force, DCP has continued its efforts to evaluate opportunities for Commissioned Officers to provide their exceptional services to meet public health needs specific to rural America.

Commissioned Officers are presently assigned to all HHS agencies and to a number of agencies outside HHS. Currently, 1422 Commissioned Officers (or roughly 34.2 percent) staff facilities in non-metropolitan areas and 0.9 percent serve in Territories and International areas. Analysis by provider-type showed that placement in rural areas includes 230 dentists (43 percent of all dentists), 280 pharmacists (37 percent), 42 therapists (34 percent), 24 dieticians (32 percent), 304 nurses (28 percent), 107 engineers (26 percent), and 169 physicians (13 percent).

Program Support Center (PSC) - PSC, a service-for-fee organization, utilizes a business enterprise approach to provide government and support services throughout HHS as well as other Departments and federal agencies. Administrative operations, financial management and social resources are solution and custom-oriented.

In addition to the expansive array of support services to Federal entities, PSC also is responsible for the distribution and management of over 5,000 pharmaceutical items and health supplies worldwide. Its Supply Service Center packages pharmaceuticals for hospitals, ships-at-sea and embassies around the world. All services are provided in cooperation and sponsorship with National Institutes of Health and other federal government agencies.

The Center's comprehensive program provides technical assistance, inventory management, and logistical support to meet the packaging and distribution requirements of clinical drug trials. Through inter-agency agreements with research programs, the Center participates as the Drug Distribution Center for small to very large investigational trials involving numerous clinical centers and is able to offer several years of centralized experience in packaging, labeling, and distributing investigational drugs for clinical trials.

In the area of rural health, the Supply Service Center provides pharmaceutical

and medical supplies to Indian Health Service and Tribal run clinics. One of the products that is very useful in these rural areas is our Pharmacy Unit of Use Prepacks, which are convenient, prescription size, patient-ready units labeled for direct distribution to patients by health care providers. Dispensing these unit-of-use containers to patients is an economical and time saving alternative for the small or remote locations that do not have a pharmacist.

Substance Abuse and Mental Health Services Administration (SAMHSA) - SAMHSA is the lead federal agency for improving the quality and availability of prevention and treatment services for substance abuse and mental illness.

SAMHSA administers a combination of categorical, formula, and block grant programs and data collection activities through the Center for Mental Health Services (CMHS); the Center for Substance Abuse Prevention (CSAP); the Center for Substance Abuse Treatment (CSAT); and the Office of Applied Studies (OAS).

These programs work in a coordinated manner to develop and apply best mental health and substance abuse prevention and treatment service practices. SAMHSA serves rural areas through grants to States and community-based programs.

"We need a psychologist. There are a lot of issues that people deal with out here in the sticks with no "real" help. Oh, sure you can go to your minister, but they too live in this community and for too long and that becomes uncomfortable." - Rural Resident

Barriers to Serving Rural Communities

The HHS Rural Task Force identified a number of barriers to serving rural individuals and families, but surprisingly few that were unique to rural situations. Although rural communities share similar barriers with urban America, the ways in which those barriers manifest themselves in rural programs vary significantly. The barriers can be organized into three categories: statutory, regulatory and administrative.

In general, statutory barriers are related to legislative requirements that direct funding and payment policies. Other statutory barriers are a result of what the statutes do not require, such as outreach or special efforts to serve rural communities. Regulatory and administrative policy barriers may stem from judgments made by federal staff with limited knowledge of rural issues that unintentionally disadvantage rural communities. Additionally, federal staff have little control over how block grant funds are subsequently distributed at the State level.

Statutory Barriers

1. Requiring matching funds
Federal programs requiring a substantial match present challenges for many grantees, but particularly for some rural constituencies with limited resources. For example, the Office of Rural Health Policy's State Office of Rural Health grant program requires States to provide 75 percent of funding to match the 25 percent provided by federal grants. Rural constituencies often have fewer public and non-profit entities from which to build the coalitions that can generate needed match funding for initiation and maintenance of programs that benefit rural communities.

2. Population-based formulas
Programs with allocation formulas based on numbers of clients or anticipated costs may be biased against rural communities with small numbers of participants and the inability to "spread costs" across a larger client base. For example, the Ryan White CARE Act Title II directs States to establish consortia for the delivery of HIV-related support and medical services within areas of the State "most affected by HIV disease." Most rural communities have not had large numbers of individuals with HIV.

3. Targeting and eligibility
Programs that provide funds through States may limit rural communities' participation in these programs. For example, funds sent to States in block grants may result in great variability in rural service, as some States may target rural service areas while others do not. Tribes' access to block grant dollars is also limited. Unless statutory language specifically identifies rural or Tribal communities for service, cost factors and lack of awareness lead States to direct funds to the areas where there is greater perceived benefit for the expenditure.

4. The need for outreach
Authorizing statutes that do not require outreach efforts to providers or families result in lack of awareness of services

and limited participation. Without rural outreach language, States may not be encouraged to serve rural communities and these communities frequently never learn of opportunities. For example, although ACF's Child Care and Development block grant requires State plans to include a consumer education component for parents of all eligible children and quality initiative set-aside monies are available for rural communities, there is not a specific rural outreach requirement. This may contribute to the variability across States in the proportion of rural families receiving child care services. Thus, the inclusion of rural outreach language in this funding mechanism may be useful in focusing State efforts on informing and assisting eligible geographically isolated families to obtain needed access to child care services.

5. *Data Collection Limitations*
Concern about the undue burden of data collection and paperwork reduction has led to significant limitations on the allowable collection of data that would assist many programs to better understand and respond to the needs of rural communities. For example, the lack of available public transportation is uniformly recognized as a serious barrier to accessing services in rural communities. However, there is limited HHS program-specific information on the need for or costs of transportation in rural communities. Particularly in social services programs, little attention has been paid to defining the rural differential in these programs.

There are unique statutory barriers that are not applicable across all programs. For example, confidentiality protections limit data analysis for smaller geographic areas for CDC's National Center for Health Statistics. While providing important protections for citizens, this hinders some in-depth rural analysis of national survey data that might better inform policy making. Statutory language that requires HRSA's Quentin Burdick interdisciplinary training grants to include a research component presents barriers to smaller academic institutions that do not sponsor significant research activities.

Regulatory Barriers

The Task Force identified a number of regulatory barriers, but few unique to serving rural constituents. For example, the requirement for individual plans, periodic reporting and comprehensive final reports can represent an overwhelming burden to small rural agencies with limited staff, as they attempt to coordinate multiple funding sources.

1. Defining rural
The federal government has several ways of defining geographic areas as either rural or urban ranging from the Office of Management and Budget's (OMB) "Metropolitan-Non-metropolitan" system to the Census Bureau's definition of urban and urbanized areas, as well as several methodologies used by the Department of Agriculture. Some HHS programs, however, use no definition at all and allow their grantees to self-declare whether they serve rural communities.

The most widely used definition across the federal government and HHS is the OMB methodology. This system designates counties as either metropolitan (i.e., urban) or non-metropolitan (i.e., rural) areas. Under this definition, any county not considered a metropolitan statistical area (MSA) is considered rural. Metropolitan counties must include one city with 50,000

or more inhabitants or an urbanized area (defined by the Bureau of the Census) with at least 50,000 inhabitants and a total Metropolitan Statistical Area (MSA) population of at least 100,000 (75,000 in New England). Under the OMB definition, any adjacent counties in which at least fifty percent of the population is in the urbanized area surrounding the largest city are also included in the metropolitan area. Additional "outlying counties" are included in the metropolitan area if a substantial proportion of the employed people in the county commute to the central city or area.

Use of the OMB definition can affect application for, and awarding of, grants for rural health and social services. This is largely due to the use of counties in OMB urban/rural designations. There is great variation in the size of counties across the country. One major problem arises in the case of larger counties. Under OMB's county-based geographic classification system, many counties with substantial rural areas are designated as urban because they may contain an urban area in one part of the county. For example, San Bernardino County in California covers more than 20,000 square miles and contains a portion of the greater Los Angeles area in its western corner but also contains vast stretches of desert including Death Valley in its eastern portion. Programs and services in San Bernardino County cannot qualify for rural health and social service grants or special rural Medicare payment protections, although they may serve communities that are rural by every measure but that of the OMB.

The development of a new demographic classification system could facilitate a more effective HHS response to rural communities as well as a more precise assessment of HHS' service to rural communities.

"The health care system is highly regulated, and rural providers are particularly feeling the effects of regulation as they struggle with reimbursement and workforce challenges." - Minnesota Rural Health Association

2. Collecting data

As previously indicated, HHS programs do not routinely collect service area and outcome data that describes how and precisely where they serve rural people and communities. Sparse populations make the cost of conducting household-based representative surveys expensive and limit HHS' ability to conduct rigorous quantitative research. The diversity of rural areas and rural communities limits the generalizability of research data; service area data is not collected by race, ethnicity and disability, obscuring the diversity of rural communities. Narrow reading of privacy statutes limits the ability of researchers to collect data in rural areas because of smaller sample sizes. One notable exception is SAMHSA's National Household Survey on Drug Abuse which provides information on the prevalence of substance use in the population and collects information on the socio-demographic characteristics of users, including their place of residence.

3. Unique situations

There are a number of unique situations that are not addressed in federal regulations. For example, a substantial proportion of rural residents access drinking water exclusively through private water wells. However, private well water is not regulated at the federal or State level

and can be a significant source of contaminants and pathogens. Another example is an INS rule that mandates release of parolees prior to completion of TB treatment. Difficulty tracking these patients affects rural areas and contributes to the development of multi-drug resistant TB. Program regulations do not address situations where there may not be a road to the client, such as in Western frontier areas. Confidentiality requirements take on very different meanings in communities where there is limited anonymity.

Administrative, Policy and Resource Barriers

Most of the barriers identified were "resource" barriers, meaning that resources were inadequate to address rural problems within the scope of HHS' programs.

1. Categorical funding
Multiple agencies and constituents who responded to the Task Force's request for comments expressed that categorical and limited funding makes reaching remote populations difficult. Categories of funding begin to define the need rather than the need defining the response. Rural communities often lack the information, knowledge and capacity to identify the range of funding sources, to redefine their needs to fit the eligibility categories and to produce the reports required for funding.

2. The regional nature of rurality creates challenges
In addition, the regional nature of rural America makes it hard to serve rural residents. Frontier areas, populated largely by white Americans, differ greatly in their health needs from Southeastern rural communities, populated largely by African Americans. These differences are evident when customizing prevention programs, funding providers and measuring health status.

In some rural areas, regional identities are based on county and, sometimes, State lines. The closest medical or social service may be in the next county or the closest, larger city in another State.

3. Whom we consult
Another policy barrier internal to HHS is our interaction with constituent groups. HHS often uses national associations of State and local government representatives as proxies for those governmental entities in HHS regulatory and policy consultation processes. These organizations may not have a rural focus and may exclude the rural perspective unless specifically requested.

4. Working with States and communities
Working with States presents several challenges. The variability in their responsiveness to rural issues and inadequate institutional capacity at State and community levels limits sustained interventions. For example, States may not have well-developed systems for tracking service delivery and needs at sub-State levels.

"The health care infrastructure in many rural communities is financially fragile and thus especially sensitive to changes in Medicare's policies." - Clinic Director in Wisconsin

5. Infrastructure barriers
Rural residents need better transportation to health and social services, as well as to obtain and maintain employment. Communities should ideally have

affordable and accessible public transportation, yet inadequate resources as well as poor transportation infrastructure limit access.

Transportation for medical purposes and to serve individuals with disabilities is especially lacking. Geographic distances, road conditions and weather often limit service delivery, especially to rural elders. Distance itself is a problem, as it raises the cost of delivering services.

Workforce shortages (health care providers, personal care) limit the success of HHS' programs, where the workforce is inadequate in number and training to deliver programs to rural populations. In addition, time off from work for training is difficult, since small rural staffs must ensure coverage. Related to workforce shortages is lack of interpreters and translation services that present barriers to access to quality health care and social services by persons with limited English proficiency and persons with disabilities.

Technology, especially telemedicine, seen as a logical solution to distance and workforce problems, presents problems to rural communities which often lack the technological infrastructure to support such options. Funds tend to support pieces of it but are not available to support full participation in telemedicine programs. In addition, a large proportion of telemedicine funds has gone to academic medical centers, which, for the most part, are in urban areas.

Many local health departments lack high speed continuous Internet access (Only 48.9 percent have access); broadcast communications capacity (44.9 percent have this capacity); and facilities and equipment for distance-based training (e.g., satellite downlink, teleconferencing, web-based training). This access may be especially limited in rural health departments.

A final barrier related to infrastructure is the small number of community-based organizations in rural areas. Without existing non-profit organizations in their communities, rural areas are less likely to be eligible to apply for and receive federal or other health and human services grants.

6. Costs of delivering care in rural areas
Higher costs for providing care in rural areas, without related higher payments, are also a problem for rural communities. Rural communities do not have sufficient use of services nor demand for individual services to realize scaled cost savings. For example, rural providers that have low numbers of low-income individuals and receive a smaller percentage of State dollars through the ACF Community Services Block Grant find the nature of rural poverty frequently requires greater resources because of higher per client costs.

Providing services in rural areas often entails moving the client or the service provider over great distances, using a limited provider network and working with a client population often resistant to service. All of these conditions raise the cost of providing service.

"The cost of running a medical practice is no less expensive in a rural area than in an urban area. When I buy a stethoscope, do I get a rural discount?" - Physician in Oregon

Statutory payment caps also disadvantage rural providers. For example, the statutory payment cap for screening services at Medicare rates, sufficient for many urban screening services, is not sufficient to cover higher costs of delivering mobile mammography to rural women through the National Breast and Cervical Cancer Early Detection Program carried out by CDC.

7. Competing processes at the federal, State and local levels

Differing regulations - federal, State and local - are confusing to rural communities. Effective health and social services program delivery requires local agencies and service providers to weave a service safety net from the often fragmented array of federal and State funding options.

The ability to weave an effective net is directly related to the capacity of the community and its organizations to acquire, understand, integrate and respond to an enormous variety of program information and requirements.

Larger communities may have the resources to employ full-time grant writers and program administrators to address these formidable information demands. This situation in essence constitutes a cycle in which those that most need help are least likely to qualify. Even when successful in obtaining funding, rural communities struggle with the ability to produce the planning and reporting information required for each individual funding source.

Research and Policy-Making Efforts

A number of HHS agencies have a role in conducting research and supporting a rural perspective in policy and decision making. Much of this work is conducted to inform the public, Congress, State-level leaders, Tribal leaders, local level leaders, as well as HHS leaders and staff. The general public is also informed through these efforts. The support of rural policy and decision making runs across the Department ranging from targeted research studies to evaluation of programs as well as national meetings and conferences.

The Office of Rural Health Policy serves as a focal point for rural health issues within the Department. The Office, which was created in 1987, is charged in its authorizing language in the Social Security Act with advising the Secretary and the Department on rural health issues. ORHP reviews key Medicare and Medicaid regulations to assess the impact on rural providers and beneficiaries and also funds rural focused health services research. ORHP currently administers eight grant programs designed to expand rural health capacity at the State and local level.

HRSA, AHRQ, NIH, CMS, SAMHSA, ACF and the Office of the Assistant Secretary for Planning and Evaluation all support health and social services research on a variety of administration policies and programs including Medicare, Medicaid, mental health, substance abuse and TANF. Of these, only HRSA's Office of Rural Health

Policy and NIH offer rural-specific services research. Other HHS-supported research projects tend to be more global in nature. CDC recently produced a national chart book on rural and urban health indicators that highlighted key differences in health status between rural and urban populations.

Several of the HHS operating divisions are working to emphasize flexibility in current programs to better meet rural needs. AoA has emphasized creating flexibility in its funding streams to allow States and local Agencies on Aging to tailor programs to local needs. AoA is also working with States so that a substantial percentage of the services in a new Alzheimer's Disease Demonstration grant program are delivered to people living in rural areas.

HHS agencies and offices are also reaching out to rural constituency groups on a variety of policy and programmatic issues. CMS is currently sponsoring rural "listening sessions" with providers and association representatives on key rural Medicare issues. HRSA's Bureau of Primary Health Care annually convenes a joint task force of members of the National Rural Health Association and the National Association of Community Health Centers to discuss issues that cut across both organizations.

The Office of Intergovernmental Affairs has represented the Department on the National Rural Development Council and participated in activities of the National Rural Development Partnership since 1991. The Partnership consists of 40 State Rural Development Councils as well as the Washington, DC based National Council. IGA has worked with the Partnership to add health and social services perspectives to their economic development strategies.

Developing HHS-Wide Goals and Strategies

To begin its Department-wide planning effort, the Rural Task Force established five goals:

Goal 1: Improving rural communities' access to quality health and human services
Goal 2: Strengthening rural families.
Goal 3: Strengthening rural communities and supporting economic development.
Goal 4: Partnering with State, local and Tribal governments to support rural communities.
Goal 5: Supporting rural policy and decision-making and ensuring a rural voice in the consultative process.

These goals were intended to broadly capture most of the Department's rural programs and policy-making efforts. Each agency and staff office was asked to develop a plan addressing these five goals. Five goal workgroups used these as a basis for developing an HHS-wide plan and making recommendations to the Secretary.

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Public Comment to Inform the Task Force

Recognizing the value of input from people living in rural communities, the HHS Rural Task Force invited public comment on the five goals of the HHS Rural Initiative. Through a Notice in the Federal Register published on August 29, 2001, the Task Force encouraged people at the local, State, and Tribal levels to share their thoughts about how the Department can better serve rural communities.

More than 450 individuals and organizations shared their insight and experience. Comments ranged from people simply thanking Secretary Thompson for his focus on rural services to technical comments about the impact of particular HHS health care financing regulations on small, rural providers. The comments received were organized and analyzed in relation to the five goals of the HHS Rural Initiative. The following are the common themes that supported the work of the goal workgroups:

Goal 1: Improving rural communities' access to quality health and human services.

- Improve access to transportation services and increase vehicle ownership so rural families can attend social services appointments or medical visits, obtain and maintain employment and more readily contribute to the life of the community.
- Recruit and support more rural providers, particularly those providing mental health, substance abuse or dental services.
- Support better rural options for community-based care for individuals with disabilities and elderly people.
- Increase support for rural child care, telemedicine, Head Start, EMS, HIV/AIDS services and rural health clinics.
- Increase reimbursement for rural providers and minimize the impact of geographic payment adjustments between rural and urban providers.

Goal 2: Strengthening rural families.

- Support youth and adolescent opportunities through health and social services career development, by increasing after-school options and by partnering with rural youth organizations.
- Support adult literacy and social capital through training and educational programs to help people transition from welfare to work.
- Help families make better health, social and life-task decisions through parenting education programs.
- Increase support for rural caregivers and respite services.

Goal 3: Strengthening rural communities and supporting economic development.

- Increase technical assistance on HHS grant programs to rural communities.
- Partner with the US Department of Agriculture's Cooperative Extension Services and Vocational Training Programs offered at rural Community Colleges.
- Support telemedicine, teleservices and rural infrastructure needs.

- Provide a tax credit or expanded loan forgiveness for rural providers as an incentive for serving rural America.

Goal 4: Partnering with State, local and Tribal governments to support rural communities.

- Support State or regional rural summits.
- Build on the strength of existing partnerships with Community Action Agencies, State Offices of Rural Health, etc. to better connect HHS programs with the communities they serve.
- Foster better relationships between Tribal governments and State agencies who receive HHS funding.

Goal 5: Supporting rural policy and decision-making and ensuring a rural voice in the consultative process.

- Use a common definition of "rural" across HHS programs.
- Recognize that GPRA measures that value the most people served for the money may disadvantage rural communities because of lower volume of people served.
- Involve consumers in the policy-making process to attain a "true" rural voice.
- Form a new rural agency within HHS that looks at both social services and health.
- Integrate "rural" into Healthy People 2010 goals.

In addition to these themes, many comments offered agency specific suggestions. These program specific recommendations are being shared with the proper agency for future consideration. These comments will be used to develop further strategies for improving rural health and human services.

Cross-Cutting Recommendations: One Department Serving Rural America

Drawing from these public comments and from the individual goals submitted by each agency and staff division, the Task Force developed a series of strategies to improve how HHS serves rural communities. A number of proposals supported the Task Force's concept of "One Department, Serving Rural America." These strategies cut across all goals and most aspects of the Department and require a fundamental change in our process. These goals were pulled into a series of recommendations for restructuring the way HHS works on rural issues as a Department and with State, local and Tribal governments.

Effective, coordinated health care and social services are essential in rural communities, where resources and providers are limited. The Task Force's examination of HHS' rural support revealed that improvements could be made in program coordination and policy. Our current federal approach to providing rural services - through discrete categorical funding - makes rural service providers "specialize" in an attempt to meet grant requirements, despite the fact that many of these programs serve the same clients. Our research and policy-making efforts have not been coordinated and in some instances have been duplicative. The newly created HHS research coordination council presents an opportunity to overcome these challenges and to develop a Department-wide rural research agenda.

We also miss opportunities to inform policy-making by not distinguishing data as rural or urban or by requiring data that describes rural programs and outcomes. HHS could better serve rural communities by making a fundamental change in its approach to programs and policy-making affecting these communities. HHS needs to integrate its own programs and policy making efforts, then help States and rural communities do the same. The Rural Task Force believes that we should characterize this as "One Department, Serving Rural America."

1. **Ways we can improve rural health and social services coordination within HHS.**

- Create a formal structure within HHS with responsibility for coordinating rural policy initiatives among HHS agencies and staff divisions, as well as with external partners.

- Based on the work of this Task Force, create a cross-HHS workgroup that follows up on the proposed strategies. This workgroup would meet quarterly with the Secretary, or the Deputy Secretary, and report on HHS' progress toward achieving the goals proposed by the Task Force.

"Social service agencies in certain parts of our region continue to be underfunded with high *[staff]* turnover rates." - Rural Provider in Pennsylvania

- Enhance HHS budget documents to include a more thorough consideration of rural issues.

- Explore the feasibility of developing a rural impact analysis statement to be included, as appropriate, in all proposed regulations or regulatory changes.

- Create opportunities for HHS staff and program managers to learn about other programs that serve rural communities.

- Create a single point of entry or focal point to coordinate assistance for rural communities with limited infrastructure as they seek assistance from the Department of Health and Human Services.

- Ensure that central and regional HHS office grant officers receive up-to-date information about HHS-funded projects at the community level.

- Create an "overlay" map of community-based programs that is web-based and available to HHS staff, as well as State and community-based health and social services providers.

- Integrate the Department's technical assistance for new rural grant seekers who do not currently receive funding from HHS. Create a Department-wide plan for providing technical assistance across health and human services to rural communities, rather than a program by program approach.

- Working with the newly created HHS research coordination council, develop a coordinated research agenda to identify rural needs and assess the impact of health and social services on rural economies. Whenever possible, disaggregate rural/urban data in research funded by HHS.

2. Ways we can support the integration of primary health care, behavioral health and social services at the State level.

- Sponsor Regional HHS-wide conferences to meet with State, local and Tribal rural leaders to communicate department-wide information to participants and to listen to State and local concerns.

- Support State-level rural health and social services workshops, as part of that State's rural health meeting. At this workshop, State-level health, behavioral health and social services staff would examine the ways that they could integrate their services with local rural providers.

- Support two State-level demonstrations that would include an evaluation component, assisting those States to develop a plan to coordinate rural primary and behavioral health service providers to address rural issues. Findings from these demonstrations would be shared with federal and State staff and rural providers.

3. Support the coordination of HHS' health and social services programs at the community level.

- Support two demonstrations in small rural communities that would assist them in developing community-wide planning efforts. For example, how can the local hospital, community health

center, public health and social services departments and Head Start ensure they have adequate numbers of nurses, social workers, front office staff, etc.

- Work with the appropriate health and social services national organizations to include workshops on service provision in rural communities in their national or regional membership meetings, emphasizing the need for the coordination of services in rural communities.

- Build on earlier efforts by the Office of Rural Health Policy, the Indian Health Service and the Centers for Medicare & Medicaid Services to improve collaboration between local health providers and the local Tribal health systems.

- Identify ways to channel input from community leaders into HHS program consultation processes and share with communities the ways their input has been used.

- Consider using Secretarial authority, under the newly proposed State Program Integration Waivers, or other appropriate mechanisms to consolidate program funds at the State or local level.

- Undertake two cross-cutting policy initiatives as models (one for health services, one for social services) that seek to improve the way the Department makes policy that relates to rural communities. The health project could address health quality in rural areas. The social services project could manage an examination of whether the administrative systems (such as data reporting and performance measurement systems) for TANF, Head Start, Social Services Block Grant, Community Services Block Grant or other social services programs support the development of effective rural strategies.

Many of these proposals will be strengthened by partnerships with other federal Departments, the private sector, foundations, and other organizations. The Department will need to engage them and seek their support as it goes forward to implement many of these strategies.

Other Administration Initiatives

In the course of the preparation of this report, it became clear that the five goals of the Secretary's Initiative on Rural Communities reflect the goals of several ongoing Presidential and Secretarial Initiatives, including the New Freedom Initiative, the President's Blueprint for New Beginnings, the Border Health Initiative, the Native American Initiative and the Faith-Based Initiative. The President's Blueprint for New Beginnings, which outlined the President's first budget, as well as the New Freedom Initiative, set broad policy goals for improving the way the Government does its business and doing so in a way that improves access to needed services while also reaching out to State and local governments in an ongoing partnership. Initiatives focusing on border health and Native Americans as well as the Faith-Based Initiative echo similar refrains about improving the way federal programs serve Americans. Several consistent themes emerge: improving access to needed services; reaching out to State and local governments to foster more effective partnerships; and improving the responsiveness of federal programs.

The Secretary's Rural Initiative relates to the HHS priorities of the President's Blueprint for New Beginnings in several areas. Doubling resources for NIH, strengthening the health care safety net, reforming the National Health Service Corps' (NHSC) efforts to recruit and retain health care providers, increasing access to drug treatment and supporting the Healthy Communities Innovation Initiative all coincide with the Rural Initiative goal one of improving rural communities' access to quality health and social services. Goal two, strengthening rural families, relates to the President's Blueprint for New Beginnings by promoting safe and stable families, creating after-school certificates, promoting responsible fatherhood, supporting maternity group homes, and providing an Immediate Helping Hand for prescription drug benefits.

Two other current HHS initiatives also share some common goals with the Rural Initiative by attempting to more directly meet the needs of health care providers and the people they serve. The Secretary's Regulatory Reform Initiative seeks to reduce regulatory burdens in health care and respond faster to the concerns of health care providers, State and local governments and individual Americans who are affected by HHS rules. This activity has particular relevance for rural providers who often lack the administrative resources to deal with regulatory changes. CMS is also reaching out to the provider and beneficiary community through its "Open Door" listening sessions in a number of key areas, including rural health. The intent of this initiative is to strengthen communication and information sharing between CMS and beneficiary groups, plans, physicians and other providers.

The Border Health Initiative shares several common goals with the Rural Initiative. These include improving rural communities' access to quality health and social services, strengthening rural families, strengthening rural communities and supporting economic development and partnering with State, local and Tribal

governments to support rural communities. Specifically, the commitment to community-based, culturally competent health care is a common theme between these two initiatives.

HHS' emphasis on outreach to American Indians and the Rural Initiative reflect common goals in improving access to quality health and social services, specifically culturally appropriate services and partnering with State, local and Tribal governments to support rural communities.

The President's Faith-Based Initiative works to promote public/private partnerships that level the playing field for all faith-based and community organizations applying for federal grants. This Presidential Initiative overarches all the Rural Initiative goals toward improving rural communities' access to quality health and social services, strengthening rural families, strengthening rural communities and supporting economic development, and partnering with State, local and Tribal governments to support rural communities with particular emphasis on supporting rural policy and decision-making and ensuring a rural voice in the consultative process. Especially in rural America, faith-based organizations play a critical role in the coordination of and provision of needed health and human services.

Finally, the President's Anti-Bioterrorism Initiative and the Secretary's Rural Initiative share the similar goal of improving rural communities' access to quality health and social services. The need for strengthening the capacity for medical response and emergency services as well as creating partnerships and networks among public health, medical and public safety entities to enhance preparedness and response to threats of bio-terrorism is highlighted in both Initiatives.

Conclusion

Nowhere is the shared future of Americans more immediate and present than in many rural communities where the needs of each resident are often apparent. With this context as a setting, these communities are the best place in which to make fundamental changes and improvements in the operations and policies of HHS on a national, regional and local level. The ideal of One Department is nowhere more possible than in small communities around the country that need unified, visionary leadership that no longer ideologically and administratively separates the complementary services of HHS. Our shared future depends in great measure on our ability to secure the social and economic safety and health of all Americans. Now is the time to embrace the future of rural America, essentially all of our future, and our opportunity to lead the way in transforming the federal government's response to those in need.

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NOTES

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